an unknown dog, which he killed. The period of incubation was three months, and the duration of the disease four days. The man was not delirious at any time. Hypodermic injections of morphine and atropine seemed to decrease the severity of the spasms, but apparently did not delay the fatal termination. PATRICK (Chicago).

SCRIVENER'S PALSEY NOT SOLELY PEN FATIGUE. C. H. Hughes, M.D. (Alienist and Neurologist, XVII., Oct., 1896.)

This is a brief article setting forth the author's views upon "occupation" palsies. He denies that the occupation is the sole cause of the disease, and attributes it to a neuropathic organism that, by reason of excessive strain or overwork, becomes tired. The occupation is the determining factor, but to a very limited extent the predisposing cause of these neuroses. JELLIFFE.

NEURASTHENIC HÆMATEMESIS.

Dr. Ausset (Medical Week, Sept. 4th, 1896), reported at the French Congress of International Medicine repeated hæmatemesis in a patient with decided neurasthenic symptoms, not hysterical. The first attack was the result of overwork, the second followed a violent fit of anger. The possibility of tuberculosis, ulcer or cancer was carefully eliminated. MITCHELL.

ABSENCE OF CREMASTER REFLEX IN NEURASTHENIA.

M. Critzman stated his conclusions from an examination of nine cases of hereditary neurasthenia, to the Société de Biologie (Gazette Hebdomadaire de Médécine, July 30th, 1896). The cremaster reflex is almost never absent in normal individuals; it is absent in hereditary neurasthenics on both sides; it is also absent in persons having suffered with severe varicocele, and in those who have double orchitis. In acquired neurasthenia the reflex, so far as C——'s observation has extended, has been found normal. Finally there does not seem to be any connection in neurasthenia between loss of cremaster reflex and impotency. MITCHELL.

DES DEVIATIONS DU RACHIS EN NEUROPATHOLOGIE. (The deviations of the spinal column in neuropathology.) (Revue d'Orthopédie, 1896.) By Charles Mirallié.

The writer attempts to determine the frequency of deviations of the spinal column in nervous diseases. He depends on cases observed by himself and on those reported by others. A slight scoliosis may occasionally be found when hemiplegia has lasted a long time, and it seems to be the result of an attempt to remove the weight of the body from the paralyzed limb. It may also be observed in the infantile cerebral form of hemiplegia. The difference in the length of the limbs also aids in the production of scoliosis. Deviation of the spinal column has been found associated with idiocy, and in cerebellar hereditary ataxia.

Deviations of the vertebral column are common in anterior poliomyelitis of childhood, and usually develop late in the process. They are partly the result of unequal growth of the limbs, partly of atrophy and contracture of muscles, and of atrophy of the vertebræ. They occur also in the chronic form of anterior poliomyelitis, though rarely, and in Little's disease, and they may be an early sign of Friedreich's disease. Unless due to spontaneous fracture or atrophy of the vertebral column, they are not a sign of tabes. They occur rarely in multiple sclerosis, and are very common in syringomyelia, and are noted in Morvan's disease. Dejerine considers deviation of the spinal column a sign of great value in the disease described by him and Sottas as interstitial, hypertrophic, and progressive neuritis of childhood. Scoliosis is very common in sciatica, and usually the convexity is toward the affected side. The position seems to be instinctively assumed in order to put the painful limb at rest. In some cases the convexity is toward the sound side, in other cases the convexity may alternate from one side to the other. Lumbar lordosis is not uncommon in progressive myopathy, and the peculiar gait observed in this disease has been compared to that of a duck (démarche du canard). Kyphosis has been observed in acromegaly as well as in the condition of osteo-arthropathy described by Marie, which closely resembles it.

Mirallié reports a case of hysterical scoliosis with cure. He thinks that in many of the cases of scoliosis of adolescence a history of some neuropathy in the ancestors may be obtained. SPILLER.

NEUROPATHOLOGY.

ASSOCIATION OF ACROMEGALY, EXOPHTHALMIC GOITRE, PHTHISIS AND GLYCOSURIA.

Medical journals frequently contain reports of cases of acromegaly, but the association of this disease with three other apparantly diverse affections is so rare that it becomes of more than passing interest. An instance of this "remarkable combination" is recorded by Dr. George R. Murray in the Edinburgh Medical Journal, February, 1897.

Miss U., thirty-seven years old, single. At the age of twelve the thyroid gland became distinctly enlarged. From this time to the age of twenty she worked hard as teacher, and greatly suffered at night from a dull, aching pain in the left mastoid region. This pain gradually extended all over the head and became constant, while the thyroid gland increased in size, firmness and consistence. The expression of the face was fixed, denoting suffering of mind and body; forehead wrinkled transversely and vertically, and the supra-orbital regions were thickened. Eyeballs prominent, palpebral fissure narrow, upper eyelid drooping. The nose, lips and lower jaw typical of acromegaly. Most of the teeth are absent. Mastoid process large but normal in appearance. The thyroid gland quite large; the right lobe about the size of a hen's egg, the left nearly as big, while the isthmus was even larger than the right lobe. The spine of the seventh cervical vertebræ was large and prominent, and there was a slight anterior curve of the spinal column in this region. The second rib thickened on each side, while the junction between the manubrium and the body of the sternum was marked by a prominent ridge. Skiagraphs of a hand and foot were taken with the following result: The total enlargement of the hand is due to an overgrowth of the soft tissues. The shafts of the phalanges are thickened, but the ends do not appear to be larger than normal. Neither the metacarpal bones nor the phalanges are increased in length. The middle and terminal phalanges of each finger, the (proximal) epiphysis is separated from the shaft by a narrow line, indicating that complete osseous union has not yet taken place between the two. The foot shows the increase in the soft structures, but the outlines of the bones are not well marked to indicate whether any change has taken place in them or not.

The skin soft and moist, and freely perspired. The pulse frequent, 120-140 beats in the minute—regular, soft and compressible. Cough and expectoration present. Examination of the chest revealed tubercular consolidation, with softening of the upper part of the upper lobe of the left lung. The urine clear, pale, acid in reaction; sp. gr. 1035. The single sample which was examined contained 40 grs. of sugar to the ounce.